DENNIS LEE THIAN POH & ORS A

v.

DR MICHAEL SAMY & ANOR

HIGH COURT MALAYA, KUALA LUMPUR B
LAU BEE LAN J
[CIVIL SUIT NO: S-22-212-2002]
22 MARCH 2012

CIVIL PROCEDURE: *Pleadings - Facts not pleaded - Whether plaintiff's case departed from pleadings - Whether court dismissed action* C

TORT: *Negligence - Medical negligence - Patient died following collapse and subsequent blood loss after delivery - Dependency claim - Whether plaintiffs' case departed from pleadings in relation to cause of death - Whether defendants breached duty of care - Whether second defendant vicariously liable - Whether plaintiffs' claim allowed* D

Several hours after delivering her second child at the second defendant's hospital, Gleneagles Hospital (KL) Sdn Bhd ('Gleneagles'), a lawyer ('the deceased') died following collapse and subsequent heavy blood loss. She was a patient of the first defendant, a consultant obstetrician and gynaecologist, who had a practice at Gleneagles. The deceased's husband and her two children, claiming through him, brought the instant dependency claim against the defendants under s. 7 of the Civil Law Act 1956 founded upon alleged negligence and breaches of duty and of contract. The plaintiffs specifically pleaded that the deceased's death was caused by either a massive post-partum haemorrhage ('PPH') in the course of induction or excessive bleeding due to a uterine tear. The defendants submitted that the deceased did not and could not have suffered PPH during induction because, by definition, PPH was an event that happened after delivery while induction was done before delivery. On the allegation of uterine tear, the defendants contended that neither the histopathology report nor the first defendant's examination of the uterus showed it was torn or ruptured. The defendants objected that the plaintiffs had presented a different case from the one they had pleaded. The first defendant contended that he had acted in accordance with what was expected of him in law. The second defendant denied it had breached any acceptable standard of care in private hospitals in Malaysia or that it had negligently caused the deceased's death. It also contended that it was not vicariously liable for the acts or omissions of the first defendant as he was an independent contractor. E F G H I

Held (dismissing claim with costs):

(1) The plaintiffs had failed to prove their pleaded case that the deceased's death was caused by PPH in the course of induction or excessive bleeding due to a uterine tear. The plaintiffs materially departed from their pleaded case. Parties must necessarily be bound by their pleadings and when there was a marked departure from the pleaded case, as was the case here, the court had no option but to dismiss the claim on that ground alone. (paras 17 & 104)

(2) The plaintiffs did not prove that the cause of death was PPH but was due to AFE (Amniotic Fluid Embolism) which took place shortly after 4am on 5 November 2000. As medical literature disclosed, for patients who suffered a cardiac arrest (as the deceased did in this case), the percentage of survival was 8%. The deceased succumbed to AFE despite the efforts made by the first defendant and team of medical specialists and medical support staff. (para 104).

(3) The plaintiffs failed to establish that the second defendant had breached the applicable standard of care for private hospitals in Malaysia. There was no reliable evidence as to what was the applicable standard of care for private hospitals in Malaysia in the year 2000 which the second defendant had breached. (paras 89 & 104).

(4) The second defendant was not vicariously liable for the first defendant's acts and omissions. The evidence showed that upon her admission to the hospital, the deceased and the first plaintiff had agreed to be bound by the second defendant's conditions of service which, *inter alia*, stated that all consultants at the hospital were independent practitioners whose instructions would be carried out by the hospital and its nursing staff. The deceased also specifically chose the first defendant as her obstetrician and engaged him herself. (paras 93, 94 & 104)

Case(s) referred to:

Aik Ming (M) Sdn Bhd & 8 Ors v. Chang Ching Chuen & 3 Ors & Another Case [1995] 3 CLJ 639 CA ***(refd)***

Anjalai Ammal & Anor v. Abdul Kareem [1968] 1 LNS 8 FC ***(refd)***

Arulappan Kannan v. Dr Suresh Chopra & Ors [2011] 3 CLJ 662 HC ***(refd)***

BPI International Finance Ltd v. Tengku Abdullah Ibni Sultan Abu Bakar [2009] 4 CLJ 599 CA ***(refd)***

Bull and Another v. Devon Area Health Authority [1993] 22 BMLR 79 ***(refd)***

Cassidy v. Ministry of Health [1951] 1 All ER 574 ***(refd)***

Chester v. Afshar [2002] 3 All ER 552 ***(refd)***

Cojocaru (Guardian Ad Litem) v. British Columbia Women's Hospital And Health Center [2011] BCCA 192 ***(refd)***

Dr Chin Yoon Hiap v. Ng Eu Khoon & Ors & Other Appeals [1998] 1 CLJ 533 CA ***(refd)***

Dr Wong Wai Ping & Anor v. Woon Lin Sing & Ors [1999] 6 CLJ 23 HC ***(refd)***
Farraj and Another v. King's Healthcare NHS Trust and Another [2009] All ER (D) 158 ***(refd)***
Foo Fio Na v. Dr Soo Fook Mun & Anor [2007] 1 CLJ 229 FC ***(refd)***
Gimstern Corp (M) Sdn Bhd & Anor v. Global Insurance Co Sdn Bhd [1987] 1 CLJ 123; [1987] CLJ (Rep) 102 SC ***(refd)***
Gold v. Essex County Council [1942] 2 KB 293 ***(refd)***
Hor Sai Hong & Satu Lagi lwn. Universiti Hospital & Satu Lagi [2001] 8 CLJ 208 HC ***(refd)***
Lechemanavasagar S Karuppiah v. Dr Thomas Yau Pak Chenk & Anor [2008] 3 CLJ 76 HC ***(refd)***
Leung v. Campbell [1995] 24 CCLT (2d) 63 ***(refd)***
Liau Mui Mui v. Dr R Venkat Krishnan [1999] 1 CLJ 207 HC ***(refd)***
Meyer Estate v. Rogers [1991] 6 CCLT (2d) 114 ***(refd)***
National Justice Compania Naviera SA v. Prudential Assurance Co Ltd [1993] 2 Lloyd's Rep 68 ***(refd)***
Pekan Nenas Industries Sdn Bhd v. Chang Ching Chuen & Ors [1998] 1 CLJ 793 FC ***(refd)***
RHB Bank Bhd v. Kwan Chew Holdings Sdn Bhd [2010] 1 CLJ 665 FC ***(refd)***
Reibl v. Hughes [1980] 2 SCR 880 ***(refd)***
Roe v. Ministry of Health [1954] 2 All ER 131 ***(refd)***
Rogers v. Whitaker [1992] 175 CLR 479 ***(refd)***
Rosenberg v. Percival [2001] 205 CLR 434 ***(refd)***
Sidaway v. Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital & Ors [1985] 1 AC 871 ***(refd)***
Sistem Penyuraian Trafik KL Barat Sdn Bhd v. Kenny Heights Development Sdn Bhd & Anor [2009] 4 CLJ 57 CA ***(refd)***
State Government of Perak v. Muniandy [1985] 1 LNS 117 SC ***(refd)***
Whitehouse v. Jordan & Anor [1980] 1 All ER 650 ***(refd)***
Wu Siew Ying v. Gunung Tunggal Quarry & Construction Sdn Bhd & Anor [2011] 1 CLJ 409 FC ***(refd)***
Yew Wan Leong v. Lai Kok Chye [1990] 1 CLJ 1113; [1990] 1 CLJ (Rep) 330 SC ***(refd)***

Legislation referred to:
Civil Law Act 1956, s. 7
Evidence Act 1950, ss. 101, 102, 114(g)

Other source(s) referred to:
Yeo Khee Quan and Others, *Essentials of Medical Law*, (2004), p 145

For the plaintiffs - Sharmini Navaratnam; M/s Siva Dharma & Assocs
For the 1st defendant - Darryl Goon (Maidzuara Mohammed with him); M/s Raja, Darryl & Loh
For the second defendant - Dhinesh Bhaskaran (K Navinderan with him); M/s Shearn Delamore & Co

Reported by Ashok Kumar

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JUDGMENT

Lau Bee Lan J:

[1] This action arose following the demise of Madam Hoh Pau Yu (deceased), a patient of the first defendant, Dr Michael Samy, a B Consultant Obstetrician & Gynaecologist having a practice with a clinic at the second defendant, Gleneagles Hospital (KL) Sdn Bhd. The plaintiffs' claims against the defendants are made pursuant to s. 7 of the Civil Law Act 1956 as dependants of Madam Hoh Pau Yu (deceased). The first plaintiff, Dennis Lee Thian Poh is the husband of Madam Hoh C Pau Yu (deceased) whilst the second and third plaintiffs, the children of the same are minors and their claim is made through their father and next friend, the first plaintiff. There is no claim by the estate of Madam Hoh Pau Yu (deceased).

D **[2]** The plaintiffs' causes of action against the first and second defendants are founded upon an alleged breach of duty, negligence and breach of contract. The first defendant basically denies the said allegations and contends that *vis-a-vis* the patient, he has acted in a manner and in accordance with what is expected of him in law. The second defendant essentially denies that - (i) it has breached any E accepted standard of care in private hospitals in Malaysia; (ii) it has negligently caused the patient's death; and (iii) it is not vicariously liable even if the first defendant is found liable as the first defendant is an independent contractor.

F **[3]** The trial of this action proceeded on the determination of only the issue of liability and if liability is established, the issue of quantum of damages will consequentially be determined.

[4] Having considered the submissions of the parties I dismissed the plaintiffs' claims with costs. The reasons for the court's decision are set G out below.

Pleadings

[5] The burden of proof is on the plaintiffs to satisfy the court that on a balance of probabilities:

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(a) the defendants owed them a duty of care;

(b) the duty of care was breached;

(c) the plaintiffs had suffered damages as a result of the said breach; I and

(d) causation, ie, that it was the defendants' breach of duty that caused the plaintiffs to suffer the loss and damage. A

(Sections 101 and 102 of the Evidence Act 1950; *Essentials of Medical Law* by Yeo Khee Quan and Others [2004] at p. 145).

[6] However in the circumstances of this case I shall be addressing the issue of causation first rather than the breach of duty of care issue, the reason of which will become apparent later. B

[7] It is trite that the plaintiffs bear the burden of proving that the first and second defendants' acts or omissions caused the patient's death as opined by the Federal Court in *Wu Siew Ying v. Gunung Tunggal Quarry & Construction Sdn Bhd & Anor* [2011] 1 CLJ 409 at p. 423 F-G: C

> For the plaintiff to succeed in a claim for negligence, it is essential for him to prove among others that the injury caused to him was due to the defendant's negligence. *There must be a link between the wrongdoing and the damage caused. The burden of proving this link is upon the plaintiff* - see *Bonnington Casting Ltd v. Wardlaw* … (emphasis added) D

[8] The plaintiffs in para. 18 of the amended statement of claim pleaded: E

> The deceased underwent the induction **on or about 1920 hours** on 4.11.00. **In the course of the induction** the deceased suffered **massive postpartum haemorrhage** causing the deceased's demise. Alternatively, the deceased suffered **excessive bleeding** due to a **uterine tear**, which led to the deceased's demise. (emphasis added) F

[9] Thus according to the plaintiffs themselves, the patient's death was caused by either:

(i) massive postpartum haemorrhage (PPH) in the course of induction; or G

(ii) excessive bleeding due to a uterine tear.

[10] As highlighted by the second defendant it is significant to observe that the plaintiffs had "full medical and legal input and representation" at the time they made the aforesaid specific allegations regarding causation in the amended statement of claim. This is borne by the following: H

(i) the plaintiffs' amended statement of claim was only drafted and this suit was filed on 23 April 2002; I

(ii) the drafting of the pleading was done well after the plaintiffs had consulted their experts, Dr Lim Boon Hoe (PW2) whose report is dated 10 June 2001 and Mr DJ Tufnell, whose report is dated 30 May 2001 (PW3); and

(iii) PW2's letter dated 18 May 2001 to PW3 (bundle G p. 1) in seeking his "opinion regarding the causation of the unfortunate patient's death following childbirth" stated:

> As you know, the husband of the deceased, Mr Dennis Lee has asked me to prepare a report in order to initiate the litigation procedure against the Obstetrician and the Hospital.

[11] Learned counsel for the first defendant similarly referred to para. 18 of the amended statement of claim and submitted that they objected to the case presented by the plaintiffs as it was not pleaded. The first defendant submitted that it was common ground that the patient did not suffer from PPH during induction; the patient could not have suffered PPH during induction because by definition, PPH is after delivery and induction is before delivery.

[12] The second defendant held the same position and submitted:

> (i) Induction is the pre-labour period from before the onset of labour to when labour is established.
>
> (ii) Post-partum haemorrhage on the other hand, by its very definition, is an event that occurs post-partum, ie, after delivery.

[13] In this connection I find the first and second defendants' position in that it is impossible for the deceased's death to have been caused by massive PPH in the course of induction is confirmed when Dr Lim (PW2) conceded that the plaintiffs' contention was illogical and therefore it could not happen when it was put to him in cross-examination and had stated "… Induction has not resulted in the delivery yet, induction is only pre-labour event … (PPH) by definition is post-partum so (it cannot be that in the course of induction the patient suffered massive PPH causing the death)".

[14] In relation to the alternative allegation of uterine tear, I find this allegation is unwarranted in that the evidence adduced showed the contrary as:

(i) the first defendant, the only eye witness who examined the uterus himself and found no tear or rupture;

(ii) there is no mention that the patient's uterus was either torn or ruptured in the histopathology report (bundle D p. 90).

[15] In fact as early as 12 April 2011 learned counsel for the second defendant registered their objection, which was adopted by the learned counsel for first defendant, stating:

> After assessing the evidence of Dr Tufnell (PW3) and to an extent the evidence in re-examination of Dr Lim, I find that there is a significant departure from the Plaintiff's pleaded case. For avoidance of doubt, I will want it to be recorded our objection at this stage. Will take it up in submission.

[16] In the circumstances I wholly agreed with the learned counsel for the second defendant that the plaintiffs are undoubtedly bound by their pleaded case on causation as held by the Federal Court in *RHB Bank Bhd v. Kwan Chew Holdings Sdn Bhd* [2010] 1 CLJ 665 at pp. 679-680 paras. 33 and 35 that:

> It is a cardinal rule in civil litigation that the parties must abide by their pleadings… The parties should know best as to what they want and it is not for the court to pursue a cavalier approach to solving their dispute by inventing or creating cause or causes of action which were not pleaded in the first place …

[17] Parties must necessarily be bound by their pleadings, and when there is a marked departure from the pleaded case as is the case here, the court has no other option but to adopt the time-honoured principle and dismiss the plaintiffs' case on this ground alone. Of relevance here also are the cases of superior courts cited by the first defendant namely, *Anjalai Ammal & Anor v. Abdul Kareem* [1968] 1 LNS 8 (FC), *State Government of Perak v. Muniandy* [1985] 1 LNS 117 (SC), *Gimstern Corp (M) Sdn Bhd & Anor v. Global Insurance Co Sdn Bhd* [1987] 1 CLJ 123; [1987] CLJ (Rep) 102 (SC), *Yew Wan Leong v. Lai Kok Chye* [1990] 1 CLJ 1113; [1990] 1 CLJ (Rep) 330; [1990] 2 MLJ 152 (SC) at p. 155 C-F (left column), *BPI International Finance Ltd v. Tengku Abdullah Ibni Sultan Abu Bakar* [2009] 4 CLJ 599; [2009] 4 MLJ 821 (CA) at p. 830 paras. 28 and 29.

[18] In the event I err, I will now consider whether the plaintiffs have proven their case as per the prerequisite elements mentioned in para. 5 above having regard to the issues raised by the plaintiffs.

Failure To Explain The Risks Of Induction To The Patient

[19] The plaintiffs submitted that misoprostol or its trade name cytotec is not licensed for use in induction of labour; it is marketed and used for the prevention and treatment of peptic ulcers. The letter from GD Searle & Co, the manufacturer of cytotec with the warning "Drug Warning on Misoprostol" was not evidence before the court. However as pointed out by the plaintiffs the said August warning letter was

alluded to in exh. D11. What is significant is exh. D11 is a positive response from ACOG (American College of Obstetricians and Gynaecologists) dated 30 November 2000 on the said August warning letter that:

> The ACOG document strongly affirms existing ACOG opinion that misoprostol - a drug manufactured for treatment of gastric ulcers under the trade name Cytotec© - can be used safely and effectively off-label for cervical ripening and labor induction.

This shows that medically the use of misoprostol is supported and recommended by ACOG and to date even WHO (World Health Organisation) and FIGO (International Federation of Gynaecology and Obstetrics) recommend the use of misoprostol for induction. Therefore it cannot be said that the use of misoprostol as an induction agent is contrary to medical opinion.

[20] The plaintiffs contended that since the labour was induced on 5 November 2000 which is after the August 2000 letter issued by the manufacturer of misoprostol to physicians on the safety concerns in advising against the use of misoprostol in pregnant women, Dr Michael Samy, the first defendant would be deemed to have notice of the warning letter and therefore proceeded at his peril when he decided to use misoprostol to induce labour on the patient, Mdm Hoh Pau Yu on 5 November 2000.

[21] As correctly submitted by the first defendant, as the said warning letter *per se* was not in evidence and it is not proven that the first defendant received any warning letter and neither is it known that the said letter was sent to Malaysia, it would be grossly unfair to make reference to the said letter and to deem that the first defendant should have known of its contents and should not use cytotec for induction.

Whether The Dosage Used For Induction Of Labour Was Appropriate

[22] The plaintiffs sought to rely on the (i) ACOG Clinical Management Guidelines on Induction of Labour, ACOG Technical Bulletin No. 10, a summary of which is found in the American Family Physician dated 15 July 2000 (appendix A); (ii) Obstetric Use of Misoprostol vol. 4, issue 1 September 2002 Indiana Perinatal Network by Dr Dan Sunkel (appendix B); and (iii) Society of Obstetricians and Gynaecologists of Canada (SOGC) Clinical Practice Guidelines No. 107, August 2001 (appendix C). All these three appendixes are annexed to the plaintiffs' written submission. The court is of the view that these documents cannot be relied on by the plaintiffs as they were not referred/tendered at the trial and the defendants nor their witnesses were never allowed to address the same.

[23] As pointed out by the first defendant, prior to 5 November 2000 and at the time the first defendant used cytotec on the patient, the only substantial study on the use of misoprostol was the publication of the International Journal of Gynecology & Obstetrics in 1996 (exh. D12) which was supportive of the use of misoprostol for induction/augmentation and the dosage of 100mcg intravaginally.

[24] The warning given by the manufacturers of cytotec (bundle D p. 91) contained in the pamphlet accompanying the drug is "Cytotec is contraindicated in pregnant women and in women planning a pregnancy as it increases uterine tone and contractions in pregnancy which may cause partial or complete expulsion of the products of conception". As correctly pointed by the first defendant what is significant is that an increase in uterine tone is necessary in bringing about labour; as to the consequences of causing "partial or complete expulsion of the products of conception", it did not occur in this instant case as the third plaintiff was delivered well.

Warning Of Risks Associated With Cytotec

[25] The first plaintiff, PW1 stated that the first defendant did not explain how the induction was to be carried out or what drugs were going to be used for the induction and did not explain any risks of induction of labour or augmentation of labour. The plaintiffs contend no information on the risks and benefits of using misoprostol for induction was provided to the patient to make an informed decision whether to proceed with the induction of labour using misoprostol.

[26] It is not disputed cytotec was used in the augmentation of the patient's labour namely (i) 100mcg was first inserted per the patient's vagina at 7.20pm on 4 November 2000 (ii) when ARM was effected and the half tablet of cytotec (100mcg) came out together with the flowing liquor "almost intact", a quarter tablet of cytotec (50mcg) was given to the patient (WSPW1 Q&A 18 and 19).

[27] There was no warning of any material risk in relation to the use of cytotec because in the year 2000, the medical world was not aware of any material risk. In 2000 there is no evidence that the medical profession knew of any material risk that is associated with the use of cytotec for induction/augmentation of labour. Literature adduced by the plaintiffs were published after 2000 (see *Dr Chin Yoon Hiap v. Ng Eu Khoon & Ors & Other Appeals* [1998] 1 CLJ 533 (CA); *Roe v. Ministry of Health* [1954] 2 All ER 131; [1954] 2 QB 66 (English Court of Appeal). On the other hand misoprostol remains a recommended drug for the induction/augmentation of labour by FIGO (exh. D26) and WHO (exh. D27).

[28] There is merit in the first defendant's submission that there was no breach of any duty of care owed to the patient in not informing of any material risk that may be associated with the use of cytotec:

(i) the duty the law imposes is the need to warn of material risk and not just of any risk (see *Foo Fio Na v. Dr Soo Fook Mun & Anor* [2007] 1 CLJ 229; [2007] 1 MLJ 593 at p. 603 where the Federal Court adopted the test propounded in *Rogers v. Whitaker* [1992] 175 CLR 479 at p. 489 (HC of Australia) and amplified in *Rosenberg v. Percival* [2001] 205 CLR 434 at p. 440;

(ii) as there is evidence that the medical world then did not know of any risk in the year 2000 or particularly at the material time, 4 November 2000 and 5 November 2000;

(iii) DW1's evidence that cytotec was commonly used by obstetricians in Malaysia and in the second defendant hospital, pre-cut tablets into halves (100mcg) and quarters (50mcg) are stored in separate containers and made readily available at the Hospital's Labour Ward;

(iv) evidence of the first defendant's expert witness, Datuk Dr Aziz, a Sr Consultant Obstetrician & Gynaecologist (DW3) that at that time and in Malaysia there was no generally known risk associated with cytotec and in 2000 no recommended dosage for induction or augmentation of labour and in his written opinion stated that the 100mcg dosage used by the first defendant was not uncommon and there were no protocols issued by the Ministry of Health or any other authoritative body in 2000 of its use or dosage for induction or augmentation of labour (bundle F p. 114).

[29] The evidence revealed that the patient was anxious to get on with the augmentation of her labour as could be inferred from her response to the first defendant "might as well, might as well" to augmentation of labour. The patient was admitted on 4 November 2000 at about 2.19pm; at about 5.30pm had a slight show with weak contractions, one contraction every six minutes lasting for 25 seconds (1:6:25); had mild tightenings and the foetal head was noted to be in the pelvic brim indicating that the patient was in the early stages of process of labour. It was around 7.20pm when the option of augmentation was raised by the first defendant and discussed with the patient, more than seven hours of waiting by the patient for labour to progress (WSDW1 Q&A 9, 10 & 11). Therefore I agreed with the first defendant it would be speculative whether the patient would have declined augmentation with cytotec because of the possibility of uterine hypercontractility if she was told the recommended dosage was 100mcg.

[30] The RCOG Guidelines (exh. P21) no doubt speaks of the risk of uterine hypercontractility with the use of misoprostol which can lead to foetal distress or cervical tears and uterine rupture. However none of these risks occurred in this case as the plaintiffs have conceded there is no foetal distress and the evidence showed there was no cervical tear or uterine rupture.

Risk Of Death From Hyperstimulation Of Uterus

[31] The plaintiffs contended that the events during and after the induction of labour resulted in the patient's death. I agreed with the first defendant's submission that this contention is not tenable as the court was informed that the issue in this case is whether the patient died of PPH or AFE (Amniotic Fluid Embolism), a position taken even by the plaintiffs' experts and of which they testified that the patient died of PPH.

[32] The plaintiffs' contention that hyperstimulation from using cytotec can cause AFE is not acceptable as (i) there was no such evidence adduced and (ii) even the plaintiffs' expert, PW2 expressed in his opinion (bundle F, p. 7 para. 4.1) that in identifying the cause of the massive obstetric haemorrhage leading to the patient's demise under the heading "4. CAUSATION" stated:

> the following differential diagnoses have to be considered:
>
> (a) [AFE] with Disseminated Intravascular Coagulation (DIC);
>
> (b) [PPH] culminating in a Massive Obstetric haemorrhage and DIC.

and not cytotec.

[33] The plaintiffs submitted for the purpose of explanation on risk, it is not necessary for the plaintiffs to prove the cause of death is by PPH or AFE but it is sufficient to show that it is a special or unusual risk or material risk of induction of labour using misoprostol that it can lead to hyperstimulation (it did take place here) which can lead to uterine atony (it occurred here) and subsequent DIVC (disseminated intra vascular coagulation) due to blood loss from either PPH or AFE and death.

[34] The aforesaid contention is untenable. Dr Lim (PW2) was of the view that there was uterine tachysystole hyperstimulation (rapid contractions) before the birth of the baby which was not appreciated by the midwives and these conditions have the potential of causing damage to the baby and mother. However the evidence showed that the patient did not die from hyperstimulation as (i) it is undisputed the baby's foetal

heart remained satisfactory, (ii) the patient's condition immediately after delivery was also satisfactory as photographs were taken with the baby and (iii) first defendant testified:

> Hyperstimulation, if significant, would often result in uterine rupture, cervical tear and/or foetal distress. In this case, there was no uterine rupture, there was no cervical tear and there was no evidence of foetal distress (as can be seen from the CTG recordings of the foetal heart). Thus the hyperstimulation in this case was not significant enough to cause any deleterious effect to either the Patient or the baby. (WSDW1A Q&A 36)

[35] The question before the court therefore is not should the first defendant have notified the patient of the risk of hyperstimulation of the uterus that could lead to death. It is for the plaintiffs to prove:

> 28.1 that there were known material risks in the use of Cytotec;
>
> 28.2 that there was a failure to warn of those risks;
>
> 28.3 that the Patient if warned of those risks, would not have agreed to the use of Cytotec for augmentation;
>
> 28.4 that one of those known material risks did actually occur;
>
> 28.5 that risk led to PPH (which is the Plaintiffs' case); and
>
> 28.6 that the Patient died of PPH.

(see para. 28 p. 11 first defendant's submission in reply)

The Law On Informed Consent

[36] It is not disputed that the Federal Court case in *Foo Fio Na v. Dr Soo Fook Mun & Anor* [2007] 1 CLJ 229 recognises that a medical doctor has a duty to disclose material risks associated with a treatment being given. The case of *Foo Fio Na* (*supra*) did not speak of "informed consent". The duty to advise of material risks is a separate and distinct duty not related to consent and or "informed consent". The concept of "informed consent" is an American one as distinctly stated in the case of *Sidaway v. Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital & Ors* [1985] 1 AC 871 cited by the first defendant. At p. 894, the House of Lords opined:

> The juristic basis of the proposed substitution which originates in certain state court jurisdictions of the United States of America and has found some favour in modified form by the Supreme Court of Canada, appears to me, with great respect, to be contrary to English law. Its foundation is the doctrine of "informed consent" which was originally based on the assumption made in U.S. Court of Appeals,

District of Columbia Circuit, in *Canterbury v. Spence*, 464 F. 2d 772, (where the cynic might be forgiven for remarking it enabled a defence under the State Statute of Limitations to be outmanoeuvred,) that, *prima facie*, the cause of action in a case of surgery was trespass to the person unless "informed consent" to the particular battery involved in the surgical operation could be proved. From a period long before American independence this, as I have pointed out, has never been so in English law. The relevant form of action has been based in negligence, ie, in assumpsit, alone.

What Is Material Risk

[37] The two authorities cited by the plaintiffs (i) *Meyer Estate v. Rogers* [1991] 6 CCLT (2d) 114 and (ii) *Reibl v. Hughes* [1980] 2 SCR 880 are Canadian cases and do not represent the law applicable in Malaysia.

Is The Alternative Risk Of Death From Hyperstimulation A Special Or Unusual Risk Requiring Disclosure

[38] To support the concept of "special" or "unusual" risk the plaintiffs cited the Canadian cases of *Leung v. Campbell* [1995] 24 CCLT (2d) 63 and *Cojocaru (Guardian Ad Litem) v. British Columbia Women's Hospital And Health Center* [2011] BCCA 192 and this concept is at odds with the Federal Court's decision in *Foo Fio Na* (*supra*) and is not part of the Malaysian law. For the purposes of causation in relation to advice, the law applicable is that propounded in *Rosenberg v. Percival* (*supra*) in relation to the principle in *Rogers v. Whitaker* (*supra*) which the Federal Court adopted in respect of the advising of risks namely:

(a) At the first level, the risk must be related to in a physical sense to the injury that was suffered;

(b) At the second level, there must be a causal connection, in the legal sense, between the failure to warn of the material risk and the occurrence of the injury;

(c) It requires the satisfaction of two criteria. The first criterion is a breach of the duty to warn of a material risk, that risk having eventuated and caused, in the physical sense, injury to the patient. The second criterion is that, had the warning been given, the injury would have been averted, in the sense that the relevant "patient" would not have had the treatment in question.

[39] As regards the issue of causation, in relation to the first criterion as to whether the alleged risk was associated with the injury that is suffered or is the subject matter of the complaint or claim, the answer is in the negative. I rest the reasons for this finding based on what I

have discussed at paras. 25 through to 35 above which revealed that it is not the plaintiffs' case that cytotec caused the unfortunate demise of the patient and neither did the patient passed away because of cytotec.

[40] In relation to the second criterion of whether the patient would have refused the use of cytotec had there been some warning of risks, as the patient is now deceased, it proves a difficult issue to establish. Granted that the patient is a lawyer and is intelligent, I find PW1's evidence that if the patient was warned of the risks, she would have refused cytotec is speculative and self serving. On the other hand the first defendant was with the patient. He provided her with the option of augmenting labour and he said: "The patient was keen to augment labour as she was already admitted into hospital and in her own words, I clearly recall, she said "might as well, might as well". This evidence was unchallenged which logically means the patient would still have opted for augmentation with cytotec even if told that uterine tachysystole may occur with the use of cytotec (tachysystole occurred before delivery of the third plaintiff but did not cause harm to either the patient or the third plaintiff as referred to in paras. 31 - 34 above).

[41] At its highest, I find it cannot be said on a balance of probabilities, that the patient would have refused augmentation by the use of cytotec if she was told of the risks associated with it (it is my finding that the first defendant has led evidence in the year 2000, there is no evidence of any material risk associated with the use of cytotec for induction/augmentation of labour), given that cytotec is a drug commonly used for induction/augmentation of labour and remains a recommended drug for induction/augmentation of labour by FIGO and WHO (as addressed in paras. 19, 23, 24 and 27 above).

[42] As for the case of *Chester v. Afshar* [2002] 3 All ER 552 relied on by the plaintiffs, it appears that the plaintiffs are approbating and reprobating when they had earlier taken the position that English law is no longer applicable in relation to the duty to advise of material risks or failure to so advise. Be that as it may, in *Chester v. Afshar* (*supra*), the risk, nerve damage and paralysis materialised and caused the injury which was the subject matter of the suit. In the instant case, the patient did not die from hyperstimulation and neither of the experts including the plaintiffs' experts have postulated this. The case presented the cause of death as being either PPH or AFE.

PPH

[43] To reiterate the plaintiffs' pleaded contention is the patient's demise was caused by (i) massive PPH in the course of induction or (ii) excessive bleeding due to a uterine tear (see para. 18 of the amended statement of claim in para. 8 above).

[44] The patient did not suffer from PPH during induction because by definition, PPH is bleeding in excess of 500mls within 24 hours of delivery and induction is before delivery. PW2, Dr Lim Boon Hoe, the plaintiffs' expert conceded that the contention is illogical and agreed that it cannot happen. Based on the plaintiffs' pleaded case, the plaintiffs' claim is not made out.

[45] As to the alternative allegation of uterine tear, there is evidence to the contrary in that the first defendant examined the uterus himself and found no tear or rupture. The histopathology report supported his evidence as there is no mention that the patient's uterus was either torn or ruptured.

Other Issues Related To PPH

[46] The crux of Dr Lim's opinion is the patient "... suffered massive primary postpartum haemorrhage from a uterine event and developed severe DIVC following this" (bundle F p. 9 para. 6.9).

Alleged Continuous Bleeding Or "Ongoing" Blood Loss

[47] Dr Lim's opinion is that "while the uterus appeared to be contracted, Mdm Hoh **continued to bleed vaginally and this continued to be the case when she began to decompensate**. When the Obstetrician arrived at 4.30am, she was given an infusion of Nalador, which is a prostaglandin. This is to keep the uterus contracted. In spite of this, Mdm Hoh **continued to bleed vaginally**." ... "The clinical picture was more consistent with hypovolaemic shock from a **massive on-going blood loss**".
(emphasis added) (bundle F p. 9 para. 6.6, p. 8 para. 5.7).

[48] Dr Lim in cross-examination explained that the cause of the patient's collapse "... It is cumulative bleeding leading to Hypovolaemia and hypoxia".

[49] I find Dr Lim's conclusion is inconsistent with contemporaneous medical records for the following reasons:

(a) Dr Lim ignored the fact that according to the medical records active bleeding had ceased by 3.20am on 5 November 2000.

(b) Insufficient weight given to the fact that the first defendant left around 3.30am on 5 November 2000 after observations of "no active bleeding" and the patient's uterus had contracted.

(c) Evidence from Dato' Dr Mohamed Hassan (DW5), the specialist intensivist that there "was no evidence from any of the records of any continuous blood loss or "ongoing" blood loss".

A **Alleged Massive Blood Loss**

[50] I find there is no evidence of any massive blood loss except for the postulation by Dr Lim.

[51] Dr Lim's estimates of blood loss by the first defendant was that
B it was much more than what first defendant has estimated and thus there was massive blood loss. The first defendant stated in his clinical notes that the blood loss was more than average which he explained meant blood loss of around 250mls; testified orally the patient's blood loss before 4am on 5 November 2000 to be approximately 357.5mls.
C Dr Lim testified a fully soaked pad could contain 200mls of blood and a fully soaked incontinence pad 500mls of the same. He explained his estimates were based on his own experiment done before he came to the court of weighing the dry pads; soaking them with water and reweighing and the difference in grams would equate to milliliters amount
D of blood. Thus in this proceedings Dr Lim estimated the 3/4 pad would hold around 150mls and the 1/4 soaked incontinence pad would hold around 125mls of blood.

[52] However based on findings of a paper by M/s Bose, Regan and Paterson-Brown titled "improving the accuracy of estimated blood loss
E at obstetric haemorrhage using clinical reconstructions" (exh. D15), it is shown in diagram B in exh. D15 (p. 921) that a sanitary pad "saturated" can only hold 100mls of blood and diagram D in exh. D15 (p. 921), an incontinence pad soaked at 250mls. I agree with the submission of the learned first defendant counsel that although the
F incontinence pad in diagram D is not fully saturated, one cannot contend by looking at the diagram D that it can hold twice the amount as looking at the diagram D, one cannot say that the incontinence pad is only 1/2 saturated.

G **[53]** Dr Lim postulated that perhaps there was accumulation of blood either in the uterus or the vagina which is concealed. However this contention can be debunked by the fact:

(a) there is no evidence of concealed accumulation based on the records available;

H

(b) the patient's uterus was massaged by the first defendant and if Dr Lim's contention is correct, it would have flowed out per vagina during the uterine massage;

(c) if there was concealed accumulation the patient's uterus would have
I ballooned up and it would be noticeable.

[54] Dr Lim contended that the patient was severely decompensated before 4am on 5 November 2000 in that the patient displayed hypovolaemic symptoms which I find is not supported by any evidence. The Fluid Balance Chart (bundle D p. 69) showed at 3.40am the patient had urine output of 400mls; even if one accept that the 400mls was emptied at 3.40am (no evidence to this effect) this is not evidence of hypovolaemia.

Quantity Of Blood Loss

[55] I find Dr Lim's postulation of continuous bleeding and accumulated blood within the patient's vagina and/or uterus is debunked in that there is no evidence of how much blood the patient lost before she would decompensate and be in a state of severe shock. Sir Arulkumaran proffered a two-fold explanation which is enlightening and is reproduced:

(a) Discussion

> I would like to analyse the situation up to the point of taking Madam Hoh to the theatre. The approximate blood volume of an individual is about 1/12th of the weight in kilogram (sic), expressed in litres. E.g. a 60 kilogram woman will have 5 litres of blood; others consider 80 to 100 ml per kg body weight. The pregnancy weight of Madam Hoh was 62.3 kg when she attended the antenatal clinic on 05.06.2000. *Based on this weight Madam Hoh's expected blood volume would be about 5 litres. For someone to collapse or to state that there was massive blood loss, one considers the loss of one blood volume within a 24 hour period; the blood volume is considered as 7% of ideal body weight. Other definitions of massive blood loss for a woman to collapse include 50% of blood volume loss within 3 hours or a rate of loss of 150ml per minutes* (Reference – Page 5. Point 7 in Blood transfusion in Obstetrics – RCOG Green Top guidelines No.47; Dec 2007; modified July 2008). *Two or three litre blood loss within hours were not observed in Madam Hoh's case as this would have been obvious to the care giver.*
>
> *One should see excessive blood loss of at least roughly about 40% to 50% of the blood volume to be in severe shock. In Madam Hoh's case 40 to 50% loss should be roughly about 2 to 2.5 litres, if we accept her blood volume to have been about 5 litres.* There was a sudden change in the general condition of Mdm Hoh i.e. sudden hypotension and excessive bleeding within 20 minutes of the previous observation despite the uterus being contracted.
>
> *Between 02.45 hrs and 04.00 hrs no large volumes of fluid either crystalloids or colloids was given. If she had excessive bleeding it is likely the caregivers would have given large volumes of intravenous fluids. The staff would have also identified excessive blood loss in excess of a litre.*

The attached pictorial chart helps us to consider the approximate blood loss. *There is nothing in the notes to suggest that the bed sheets were soaked in blood or the blood was flowing on the ground from the bed. If that would have happened the staff would have noted that and called for help and then one could state PPH was the case for the collapse.*

Based on the case notes, the assessment up to the time of Madam Hoh's collapse when there was severe bleeding at 04.00 hrs, there was no indication to suggest that she lost 2 Litres of blood; neither there was deterioration in her vital parameters [except her pulse rate]. Her general condition **deteriorated suddenly** that coincided with the excessive blood loss seen outside. Hence, *some other mechanism other than bleeding must have precipitated her sudden collapse with a drop in BP to 85/55 mm Hg.* The same mechanism might have triggered hypotension and the severe blood loss and I believe that there was coagulopathy setting in. The collapse with reduced blood flow to the uterus would have some influence on the uterine contractions. (emphasis added)
(bundle F2 pp. 5-7)

(b) J : Pulse and blood pressure, referring to?

A : It is taken by the nursing staff, p49 going to p50. On line 4 it states blood pressure 125/79 and pulse was 113. There was a question yesterday whether they were accurate recordings. The usual practice when there is an epidural is to have a blood pressure cuff. And the tube can be connected to a small machine and at the push of a button it will provide the pulse and the blood pressure. So, it is not difficult to ascertain the pulse and the blood pressure soon after delivery. As contemporaneously described, the midwife has written her observation followed by the baby's Apgar score (which says 7/9) and the subsequent line describes the management of the baby. "Suction ... baby shown to mother" all these indicate what was done soon after the delivery. And these observations must have been done during that time.

J : When?

A : Soon after delivery. At 0340 on the same page, again it says 125/79 and on the next column the pulse 113, there was difficulty in believing that these 2 observations could be identical and I believe that it is before this time and could have been identified because the time interval might have been 20 or 30 minutes apart. I refer to a literature at P7, p39. It would indicate that the rising pulse rate soon after delivery was certainly not due to blood loss and may have been due to her being unwell, vomiting. So if at 0340, the pulse is still the same, based on this chart, when I see the

patient, she was not anxious, or restless or agitated or confused, then it is unlikely that she had lost 2 1/2 litres of blood in a concealed amount. Dr Michael Samy at 0330 spoke to her and felt that she was talking and certainly she did not report these symptoms. When she collapsed at 0400, the nursing staff did not show that she was cold or pale and cold. If you take the urinary output, the catheter was put at 2230 hours, and p69 of Bundle D indicates that she had passed 400ml of urine over a 5 hour period. It equates to 80ml per hour. During this time after delivery at 0250, she was given again 500ml of Hartmann's solution and this should not have been completely run out at 0340 when the urinary output was 400ml. Therefore, urinary output has not reduced as seen on the chart. Therefore on general examination and based on the vital parameters, there was no indication she had 2 1/2 litres of concealed blood.

May I take you to p50 of Bundle D, the observation at 0340 hours, shows the midwife has noted that the uterus was contracted and 3/4 pad soaked. That suggests that some blood was coming out. If 2 1/2 litres of blood was concealed in the uterus or vagina, the uterus would have been shifted very high up, it would then be larger in size to accumulate this 2 1/2 litres of blood and this would have been spotted by the midwife who palpated the uterus to be contracted.

As a comparison my Lady, (shows mineral water bottles, 1.5 and 500ml x 2), that would be the total amount of blood in the uterus, this amount would have shifted the uterus right up and the uterus would be ballooning up and the midwife would have felt when she palpated and said the uterus was contracted. Secondly, when she feels the uterus was firm and contracted, the chances that she would have pushed the blood and the blood clots from the uterus and vagina to the exterior, to the outside. This was not observed here. So, on general examination, based on the vital parameters, and on those clinical examination of the uterus, there was no suggestion there was concealed blood in the uterus or vagina at least till 0340 hours. Dr Samy did his clinical examination at 0320 hours, and he left at 0330 hours. So in the next 40 minutes 0320 to 0400, if 2 1/2 litres were lost, it would not accumulate in the vagina or the uterus and it is likely to would have come out.

At 0400 observation, it says bleeding PV ++, it does not say there were any large clots. If blood clots accumulated in the vagina for 40 minutes from 0320 to 0400, one would have observed large clots coming out with the bleeding. The blood pressure dropping at 0400 to 85/55, in my view along with the bleeding PV ++ points to a single pathology which is amniotic fluid embolism given rise to hypotension which

causes hypoxia to the uterus and the uterus starts bleeding in addition to coagulopathy because the amniotic fluid going into the respiratory system causes DIVC perpetuating the condition.
(evidence in chief, NOP of 12.4.2011 pp. 17-20)

Alleged Source Of Bleeding

[56] Dr Lim next postulated three possible sources of bleeding:

The most common causes of Primary Postpartum Haemorrhage are:

(i) Uterine atony;

(ii) Trauma - Uterine rupture or cervical laceration; and

(iii) Retained placenta.

[57] Bleeding from the atonic uterus - It is not disputed that following delivery the patient bled more than average. The bleeding was per her vagina and her uterus was atonic. The evidence of the first defendant, DW2, Staff Midwife Siti Salimeah and the medical records comprising the Nursing Care Plan and the first defendant's clinical notes showed that the patient's atonic uterus contracted after massage and the application of drugs and there were several entries in the Nursing Care Plan of "no active bleeding". Dr Lim when cross-examined on paras. 6.5 and 6.8 of his opinion (bundle F p. 9) said "that the uterus massaged and contracted, that means good tone" and agreed that the uterus contracted to the massage and "that would describe the good tone of the uterus". Therefore the alleged "persistent bleeding" could not have been from an atonic uterus.

[58] Alleged bleeding from a uterine rupture - There is no evidence based on the contemporaneous medical records, ie, (i) the first defendant who participated in the hysterectomy at around 7.35am on 5 November 2000 said "the patient's uterus was intact. It was certainly not torn or ruptured"; (ii) the first defendant stated "there was no free fluid or blood in the patient's peritoneal cavity"; (iii) unlikely for an atonic uterus to rupture or tear after delivery and no reason given by Dr Lim for this unlikely phenomenon; (iv) the histopathology report made no findings as to any tear or rupture in the uterus.

[59] Alleged bleeding from a cervical tear - There is no evidence of a cervical tear as first defendant said he found a "first degree vaginal tear which he sutured". Dr Lim stated in his opinion in bundle F, paras. 6.7, 6.8 and 13 with respect to the histopathology report "there was a separate piece of tissue, which was the cervix." and "this report appeared very non-committal … Also, a separate piece of tissue

described as "cervix" would suggest that there was a traumatic uterine event and I feel that there was most likely a tear in the lower segment of the uterus". First defendant made it clear that that was part of the cervix that was left behind after the hysterectomy but which was noticed and subsequently removed (WSDW1 Q&A 26). There was no entry in the medical records to the effect that there was a cervical tear.

[60] Dr Lim, is a consultant obstetrician and gynaecologist and is called by the plaintiff to give expert opinion. He has no personal knowledge of the facts, despite that he appears to challenge the histopathology report of the consultant pathologist in an area of medical practice he does not profess. Neither was the consultant pathologist called by the plaintiff. Thus the court is not prepared to give any weight to Dr Lim's evidence in this regard.

Events At 4am

[61] It is the first defendant's case that what happened to the patient at around 4am, which led to her collapse, the calling of Code Blue, the need for resuscitation and the need for hysterectomy were all the consequences of an acute event triggered by AFE and which led to the demise of the patient. For the chronology of events from 4am on 5 November 2000 onwards, the court gratefully adopts the table as per annexure 4 attached to the first defendant's submission in reply as reproduced below:

5.11.2000		
Time	Event	Reference
0400	- Pt suddenly started to cough during sponging, spurts of blood came out from vagina, continued to ooze heavily. (2) (3) - Pt complained of being cold. (2) - Bleeding PV ++ (1) - Dr MS informed - Will come. (1) (3) - Dr MS also ordered blood group and crossmatch. (2) (3) - Uterus massaged - contracted when massaged. (1) (2) (3) - I/v gelafundin 10 put up. (1) (2) (3) (4) (5) - Dr Chua informed. (1) - BP 85/55; Pulse 138 (2) (3) (4) (5) - BP 85/45; Pulse 138 (6) (7)	(1) NCP (p50, D - Transcript p55, D) (2) Dr MS's Report (p96, D) (3) Nurses' Report (p99, D) (4) Transfusion Request Form (p59, D) (5) Postnatal Observation Chart (p88, D) (6) NCP (p55, D) (7) Postnatal Observation Chart (p58, D)

0410	- Pt Collapsed. (3) - "Code blue" called. (1) (2) (3) (4) - Pallor noticed. (7) - Dr Chua informed. (3) (4) - Blood requested. (6) - Pt still oozing. (4) - BP 85/55; P110 (5)	(1) NCP (p50, D - Transcript p55, D) (2) CPR form (p88, D) (3) Dr Chua's notes (p36D – Transcript p41, D) (4) Dr MS's Report (p96, D) (5) Postnatal Observation Chart (p58, D) (6) Transfusion Medicine Request Form (p59, D) (7) Nursing Report (p99, D)
0415	- RM0; Dr Raja arrives and attends to Pt with staff from ICU and other wards. (1)	(1) Cardiopulmonary Resuscitation Record (p88, D)
0425	- Dr Chua arrives. (1) (3) - Noted: (2) - Laboured breathing - pallor ++ - semi conscious, unable to communicate - BP unrecordable - (L) hand I/v gelafundine and nalador - O^2 face mask on, ECG on - 20 G I/v cannula (R) forearm set up, blood taken, drip set up. (2) - Pt shut down - hard to find veins. (2)	(1) Cardiopulmonary Resuscitation Record (p88, D) (2) Dr Chua's Clinical Notes (p36, D – Transcript p41, D) (3) Dr MS's report (p96, D)
0430	- Dr MS arrives. (1) (2)	(1) Cardiopulmonary Resuscitation Record (p88, D) (2) Nursing Report (p99, D)
0445	- Pt suddenly stopped breathing while being prepared for ICU transfer. (2) - Cardiac arrest. ECG monitoring showed idioventricular rhythm. (2) - Pt intubated. (1) (2) (3) - External cardiac massage started and was continued for 20-30 min until sinus rhythm obtained. (2) - Dr MS called Dr Dewi (Consultant Cardiologist) & Dr Rudy Yeoh (Consultant Haematologist) to assist. (3) (5) - BP remained unrecordable. (1) (2)	(1) Cardiopulmonary Resuscitation Record (p88, D) (2) Dr Chua's Clinical Notes (pp36-37, D - Transcript p41, D) (3) Dr MS's notes (p30, D – Transcript p33, D) (4) Dr Rudy Yeoh's notes (p34, D - Transcript p35, D)
0510	- 4 units whole blood transfused. (1) - Followed by 6 units of Fresh Frozen Plasma. (2) (3)	(1) NCP (p50, D - Transcript p55) (2) Dr MS's report (p96, D) (3) Nurses' report (p100, D)

0550	- Pt was seen by Dr Dewi. (1) (3) (4) - Dr Dewi orders APTT, BUSE repeat blood group. (1) (3) (4) - Pt was seen by Dr Rudy Yeoh. (2) (3) (4) - Pt was clinically pale, all pulses present. (2) - Diagnosis was DIC. "Dx DIC" (2)	(1) NCP (p51, D - Transcript p55, D) (2) Dr Rudy Yeoh's notes (p34, D - Transcript p35, D) (3) Dr MS's report (p96, D) (4) Nurses' Report (p100, D)
0615	- Decision made to transfer Pt to the ICU for further management and Stabilisation. (1) (2) (3)	(1) NCP (p51, D - Transcript p55, D) (2) Dr MS's Report (p96, D) (3) Nurses' Report (p100, D)
0620	- Bleeding +++. (1) - Pt arrives at the ICU accompanied by Dr MS, Dr Chua, Dr Dewi and Dr Rudy Yeoh. (1) (5) - On arrival, pallor +++, unconscious, bleeding profusely PV. (1) - Haemacell 5% 2 units and liver plasma 2 units, rapidly transfused over 30 minutes. (1) - Pt placed on ventilator and femoral lines were set up. (1) (2) - ECG showed that Pt was in sinus tachycardia. (2) (5) - Pt continued to bleed +++ PV.(1)(2) - BP coming down. (2)	(1) NCP (pp51-52, D - Transcript p55, D) (2) Dr Chua's notes (p37, D - Transcript pp41-42, D) (3) Dr Chua's notes (p39, D - Transcript p42, D) (4) Dr MS's Report (p96, D) (5) Nurses' Report (p100, D) (6) NCP (p55, D)
	- Skin cold and clammy, pallor ++++, not responding to painful stimuli. (4) (5) - Dr Dewi continued to assist in resuscitation and stabilization. (3) - Dr Rudy Yeoh arranged for blood and blood products. (3) - BP 150/75; HR 125 bpm (5)	
0700	- Pt still oozing from uterus/vagina. (2) - Decision to transfer Pt to the Operation Theatre ("OT") for post partum hysterectomy. (1) (2) - Pt's husband (first Plaintiff) informed of gravity of problem of continued bleeding and the need for an urgent laparotomy and hysterectomy (4) - Verbal consent obtained. (4) - Datuk Dr Nik Hussein (Consultant Obstetrician and Gynaecologist) called to assist. (2) - Pt transferred to OT as soon as OT was ready and her BP was still > 100 systolic. (2) - BP 110/64; Pulse 80. (3) (7)	(1) NCP (p52, D - Transcript p55, D) (2) Dr MS's notes (p31, D – Transcript p33, D) (3) Dr Chua's notes (p39, D - Transcript p42, D) (4) Dr MS's notes (p45, D – Transcript p46, D) (5) Dr MS's report (p97, D) (6) Anaesthetic Record (pp65-66, D) (7) Clinical Chart (p73, D)

0735	- Operation started. (1) - Pt's condition deteriorated rapidly in the OT. (3) - ECG – severe bradycardia idioventricular rhythm. (2) - CPR initiated and continued throughout the operation. (2) - Dr Dewi and Dr Mohandas (Consultant Anaesthetist) called in to assist. (3) - Pt continued to be resuscitated while hysterectomy was performed. (4) - Hysterectomy performed by Dr MS & Dr Nik Hussein. (4) (5) - (R) Int iliac artery and (L) Int iliac artery ligated by Dr Lee Sing Hong and Dr Chang King Wee (both Consultant General Surgeons). (4) - Active CPR continued for >1 1/4 hrs. (4) - Pt unrevivable especially after VF set in. (4) - BP unrecordable. (1) (2)	(1) Operation Record (p75, D) (2) Anaesthetic Record (pp65-66, D) (3) Dr Chua's notes (p39, D – Transcript p43, D) (4) Dr Chua's notes (p40, D – Transcript p43, D) (5) Dr MS's notes (p31, D – Transcript p33, D)
0910	- Resuscitation stopped. Pt pronounced dead on OT table. (1) (2) (4) (5) Cause of death: DIVC 2° to Amniotic Fluid Embolism Cardiogenic Shock (6) (7) - Dr MS and Dr Chua spoke to the first Plaintiff to obtain consent for post mortem. (3) - The first Plaintiff agreed that if it (DIVC 2° to AFE) was the clinical diagnosis of the 8 Consultants involved, he does not want post mortem. (3) - The first Plaintiff refused a post mortem. (3)	(1) Operation Record (p75, D) (2) Dr Chua's notes (p40, D - Transcript p43, D) (3) Dr MS's notes (p45, D - Transcript p46, D) (4) Dr MS's Report (p97, D) (5) Nurses' Report (p100, D) (6) Discharge Summary (p76, D) (7) Death Certificate (p101, D)
0945	- Pt's body returned to ward, last office performed, body sent to mortuary (1) (2) (3)	(1) NCP (p52, D – Transcript p55, D) (2) Nurses's Report (p100, D) (3) Dr MS's Report (p97, D)

[62] On the difference between PPH and AFE, Professor Tuffnell (PW3) during examination in chief stated: A

> In keeping it relevant to the context of this case, PPH presents with bleeding which will continue for a period of time and there is collapse. AFE will present with collapse and then because of the nature of the pathology, the bleeding will come after the collapse. So the sequence is the opposite way round. So the key determination is whether there is bleeding and then collapse or collapse and then bleeding. B

[63] The plaintiffs submitted that the conclusion of the plaintiffs' experts that the DIVC suffered by the patient was a result of massive unrecognised blood loss and not due to a sudden event of AFE is based on the fact that the exclusion criteria for entry into the UK Register of AFE is that it excludes woman with maternal haemorrhage as the first presenting feature in whom there was no evidence of early coagulapathy or cardio-respiratory compromise. In this regard I agreed with the submission of the first defendant that this exclusion criteria does not apply in this present case as there was no bleeding before the patient's 4am episode of bleeding and there was early coagulapathy or cardio-respiratory compromise. C D

[64] In this instant case I find: E

(i) there is no evidence of any massive blood loss nor was there accumulation of blood either in the uterus or the vagina which is concealed as postulated by Dr Lim as addressed in paras. 47 through to 55 above; F

(ii) there was early coagulapathy or cardio-respiratory compromise as the patient was clinically diagnosed of DIVC by the first defendant and Dr Chua (DW4), the consultant anaesthetist in attendance as soon as they saw the patient shortly after 4am (WSDW1 Q&A 21 and in cross-examination of DW1 30 May 2011 NOP p. 236; WSDW4 Q&A 15. Coagulapathy was confirmed by lab examination at 6.52am (bundle D, Radiometer Results p. 77). G

[65] In this connection the first defendant urged the court to regard PW3's evidence as very unsafe. As for PW3's evidence, I considered that when he concluded the cause of death of the patient is PPH rather than AFE, he did not get the full facts of the case. PW3 confirmed under cross-examination that: H

(i) his expert medical report (bundle F pp. 21-26) was based entirely on an eight paged document prepared by PW2 of "the clinical summary of the case … (enclosing) the intensive care record of investigations and the histology of the uterus"; I

(ii) he was not shown any medical records as at the time he wrote the report, his understanding was PW2 was seeking his advice because of his specific expertise to ensure that the view he (PW2) is giving was a PPH rather than AFE and his understanding as an expert is he could revise his opinion if anything relevant becomes available and so it was routine practice for him to write a preliminary report which he could review for further information;

(iii) that his theory of the volume of the patient's blood loss by 4am would be in the order of 2 litres;

(iv) he was unable to answer directly whether there is any evidence of blood noted in the record except to reply "not as much as 2 litres, but absence of evidence is not evidence of absence in this case";

(v) he agreed that with the loss of 2 litres of blood by 4am, one would expect the pulse rate to rise;

(vi) he left the dispute on the similar entries of BP of 125/79 and pulse rate of 113 at 2.45am and 3.40am to the determination of the court;

(vii) agreed that at 3.40am there was an entry that the patient had urine output of 400ml (from 10.40am when the cathether was inserted (bundle D p. 69);

(viii) agreed that if all the urine was passed after the birth that it is less likely that she would have had continuous bleeding.

Key Allegations Of Negligence Against The Second Defendant

[66] Assuming the plaintiffs have successfully established a breach of duty of care on the part of the second defendant (which I hold has not been proven and to be discussed hereafter), I shall now deal with the allegations of negligence against the second defendant, some of which I have addressed earlier as the second defendant adopted the submission of the first defendant wherever applicable.

Competence Of DW6 (Siti Salimeah Shafiee)

[67] The plaintiffs essentially submitted that the midwives were incompetent as (i) they failed to monitor the patient properly, (ii) they did not recognise there was cumulative ongoing blood loss in the patient, (iii) did not have sufficient skills to recognise the severity of the bleeding (iv) failed to recognise concealed haemorrhage and (v) did not convey relevant information to Dr Michael Samy on cumulative ongoing blood loss and increase in pulse rate.

[68] The second defendant's sole witness, Siti Salimeah binti Shafiee (DW6), who retired in 2002, was the senior midwife on duty at the material time (9pm on 4 November 2000). In terms of her qualifications and experience as a midwife, DW6 in examination in chief (WSDW6 Q&A 2 to 5) testified:

(i) she had qualified in 1973 as a nurse and in 1977 as a midwife;

(ii) she had worked in obstetrics in the labour ward at the Kuala Lumpur Hospital for 6 years before joining the second Defendant;

(iii) she had delivered over 10,000 babies and dealt with many complicated cases, including cases involving post-partum haemorrhage;

(iv) she had more than 20 years' experience in the year 2000; and

(v) she had been trained to, among others, monitor patients for abnormal signs, including signs and symptoms of heavy bleeding and signs of patients going into hypovolemic shock, and to take appropriate action.

[69] However as correctly pointed out by the learned counsel for the second defendant, there was no challenge by the plaintiffs in respect of this aspect of her testimony. As such I agree with the second defendant that the plaintiffs are deemed to have accepted that DW6 was a competent, experienced midwife capable of identifying symptoms and signs of PPH and taking appropriate remedial action (*Aik Ming (M) Sdn Bhd & 8 Ors v. Chang Ching Chuen & 3 Ors & Another Case* [1995] 3 CLJ 639 at p. 642).

[70] The plaintiffs contended that there is lack of close monitoring of the patient and a lack of appreciation of the uterine hyperstimulation, rapid labour in the last hour prior to delivery and did not inform the same to Dr Michael Samy.

[71] In cross-examination, when asked why having agreed that entry 1.35am "patient had one episode of type II dip", bundle D p. 99 and p. 86 DW6 showing the patient had a CTG tracing which was "luar biasa", DW6 explained:

A : Saya tidak memberitahu tapi memandangkan contraction begini, kita akan membuat assessment dahulu dan tengok tahap contractions adalah cuma dalam 30mmhg dan keadaan ini tidak memudaratkan pesakit ataupun kepada bayi.

[72] As for the case of *Hor Sai Hong & Satu Lagi lwn. Universiti Hospital & Satu Lagi* [2001] 8 CLJ 208 (HC) at pp. 213-214 cited by the plaintiffs, I find based on the evidence of constant monitoring etc. alluded to in this instant case, there was no negligence proven on the part of DW6.

Continuous Post-partum Bleeding

[73] On the night in question DW6 had personally monitored the patient's condition and despite being challenged that there was continuous bleeding whether concealed or revealed, she stood her ground that there was none as is evident from her testimony, wherein she, *inter alia*, stated:

(i) A : Catitan "Blood loss > average" [Bundle D p.58 "Postnatal Observation Chart"] bermaksud bahawa si-mendiang ada berdarah berlebihan dari kebiasaan sewaktu melahirkan anak. Saya tidak berapa ingat jumlah anggaran sebenar "volume" darah yang si-mendiang telah hilang sewaktu itu, akan tetapi saya pasti volume darah yang telah hilang cuma berlebihan sedikit dari kebiasaan sahaja. Jika pendarahan si-mendiang berlebihan dan merisaukan, saya pasti sudah mencatatkan "bleeding ++.";

(ii) Saya tak setuju [si mendiang mungkin kehilangan darah sebanyak 2 liter dan kemungkinan berada dalam keadaan "hypovolaemic shock" sebelum pukul 4.00 pagi yang tidak mungkin dikesan oleh jururawat]. Saya merawat si-mendiang pada hari tersebut sehingga si-mendiang dihantar ke ICU dan saya tidak nampak si-mendiang kehilangan darah sehingga 2 liter. Saya juga pasti tahu jika si-mendiang ada berdarah sebanyak 2 liter, kerana sudah pastinya "incontinence pad" dan pad akan berlumuran darah dan pad-pad ini harus ditukar kerap kali. Dalam kes ini hanya 3/4 pad basah dengan darah bercampur lochia pada pukul 3.40 pagi dan pukul 4.00 pagi 1 pad (iaitu pad yang sama) dan 1/4 incontinence pad basah dengan darah bercampur lochia. Saya juga masih ingat selepas si-mendiang melahirkan anaknya iaitu dari pukul 2.45 pagi hingga pukul 3.40 pagi, keadaan fizikal si-mendiang diperiksa oleh saya. Si-mendiang tidak berada dalam keadaan "hypovolemic shock" ataupun berada dalam keadaan yang membimbangkan sebelum pukul 4.00 pagi.

(iii) A : Pada lebih kurang pukul 4.00 pagi, Puan Asmah memanggil saya dan memberitahu saya bahawa apabila dia sedang "sponging" si-mendiang, si-mendiang terbatuk dan mula berdarah berlebihan. Saya terus masuk ke Bilik Bersalin untuk memeriksa si-mendiang. Saya dapati si-mendiang berdarah berlebihan. Tekanan darah jatuh ke 85/55 dan denyutan nadi si-mendiang adalah 110. Saya terus

> menelefon Dr Michael Samy dan memberitahunya apa yang terjadi. Dr Michael Samy mengarahkan saya untuk "group dan cross-match" darah si-mendiang. Saya juga memberikan 1 pint Gelafundin kepada si-mendiang atas arahan Dr Michael Samy. Saya juga memberitahu Dr Chua akan keadaan si-mendiang. Si-mendiang masih berdarah dan kelihatan pucat. Saya memberikan oksigen kepada beliau. Saya cuba untuk mengambil sample darah dari si-mendiang untuk cross-match tetapi salur darah beliau telah "collapsed". Saya memanggil "code blue" pada lebih kurang pukul 4.10 pagi. Rujuk m/s 50 dan 52. Ikatan Dokumen "D". (see also DW6 NOE 27.6.2011 pp. 17-18, p. 46, pp. 50-53).

[74] The plaintiffs urged the court to be "slow to conclude that the lack of recording of information corroborates the defendants' version that the death was caused by AFE and does not support the plaintiffs' version that (patient's) death was due to PPH" since (i) the event took place 11 years ago and the midwife has admitted that she filled the records retrospectively before handing the patient over to the nurses at the Intensive Care Unit (ICU) and (ii) as the documents are in the defendant's possession, the plaintiffs were unable to verify them.

[75] I found that DW6 has proffered a reasonable explanation as to why the "Laporan 'Nursing Care Plan'" (bundle D p. 49) which is the "turutan peristiwa yang berlaku dari 2.45 pagi hingga 6.15 pagi" was written after the patient was sent to ICU because "[D]itulis dengan segera pada masa itu kerana saya perlu serahkan laporan ini kepada jururawat-jururawat di ICU dengan secepat mungkin untuk tindakan lanjut mereka berkenaan dengan rawatan si-mendiang. Oleh itu saya tidak sempat untuk menulis laporan mengikut masa-masa tertentu dan mengikut turutan peristiwa yang berlaku … (manakala) "Laporan di muka surat 98 dan 99 adalah laporan yang ditulis beberapa hari selepas kejadian tersebut. Oleh itu saya mempunyai masa untuk menulis dengan terperinci mengikut masa-masa yang tertentu".

[76] It is understandable when Dr Chua stated that he was "unable to write notes during time of care and resuscitation" and "[h]ence notes written in chronological order as accurate as possible after death of patient" as he was confronted with an emergency situation and was focusing and prioritising his attention to the care and management of the patient then.

[77] Granted that there is no issue of fabrication and concoction arising and given the lapse of time since the incident occurred and the matter was heard and given that lapses of memory do occur with the

A passage of time, surely the contemporaneous records including clinical notes and entries of nurses in the Nursing Care Plan, are absolutely vital when assessing the cause of death of the patient. (*Lechemanavasagar S Karuppiah v. Dr Thomas Yau Pak Chenk & Anor* [2008] 3 CLJ 76; [2008] 1 MLJ 115 at pp. 122 and 123).

B *Time Taken To Respond To Event Of Heavy Bleeding*

[78] The plaintiffs contended that since the second defendant did not have written protocols dealing with PPH in the year 2000, this amounted to some form of negligence. I accepted the second defendant's C submission that this contention cannot be sustained for the following grounds. Firstly, the testimony from first defendant's three experts, DW2, DW4 and DW5 (Dato' Dr Mohamed Hassan Ariff) that the absence of written protocols did not compromise the patient's condition:

D (i) DW2 testified that while it is important to have protocols, it is more important to take appropriate action with or without protocols. See DW2 NOE 14/4/2011 p. 228. DW2 also testified that, taken as a whole, the midwives and doctors who had attended to the deceased had acted appropriately on the facts of this case. See DW2 NOE 14/4/2011 p. 245.

E Q : You were also asked by counsel for the Plaintiff about the necessity for protocols for the management of PPH.

My question is this. *Would you agree that taken as a whole, the midwives and the doctors who attended to this patient acted appropriately on the facts of this Case*?

F A : **Yes, I agree**. (emphasis added);

(ii) DW3 had testified as follows:

Q : If there is no such protocol, do you suggest that the G consultants involved and the nurses and the MO would therefore not be able to competently manage the Patient when she collapsed shortly after 0400?

A : My Lady, I did not suggest that at all.

H Q : Would that be the case?

A : *Protocols and guides are guidelines. In the absence of these guidelines, doctors by training will be competent to handle emergencies whether it is an obstetrics emergency, road traffic accidents, it is our job. I do not go around rushing asking for guideline before I treat patients. It would look quite comical.* I See DW3 NOE 24/6/2011 p. 117 & 118.

Q : Can I refer you to Bundle D, page 99. Starting at 0400, a number of things happened. It says, "During sponging, patient suddenly started to cough and spurts of blood came out from vagina and continued oozing heavily. Uterus contracted. I/V Gelafundin given, Dr Samy ordered group and cross match.

Given what is stated in the records, *you will confirm that the response of the midwives and those attending to the Patient was entirely appropriate.*

A : **Yes My Lady**. (See DW3 NOE 24/6/2011 p. 100) (emphasis added);

(iii) Q : I take you to p33 again, the 2nd paragraph. "Careful cross matched blood available for transfusion within 30 minutes". "Clinicians must be aware of the capability of their blood bank regarding timing, type and amount of blood products available in emergencies. Good communication with blood transfusion service is essential. Nature of emergency and amount of blood products must be stressed." Here the facts of our case, cross matched blood was not supplied within 30 minutes.

A : As I have said, this is the author's opinion, it varies different parts of the world and different part of blood banking services. You cannot take the standard of one university hospital in America or England and try and apply it in Malaysia. If it is the standard then the Ministry of Health would give guidelines that blood must be available within 30 minutes. I must stress that paragraph 2 also states that clinician must be aware of the capabilities of the blood bank regarding timing and type. So it is not being absolute. So the paragraph there is with conditions. Paragraph also states good communication with transfusion service is essential. And in this case, the haematologist was present at 0550. Anywhere in the world you won't get a haematologist at 0550.

[79] Secondly, as aptly pointed out by the second defendant, the opinions of the experts are borne out in the sequence of events that occurred:

(i) Once the deceased started to bleed at 4am, she was attended to immediately by DW6 who shortly thereafter sounded Code Blue when the deceased collapsed.

(ii) The deceased was thereafter promptly attended to by the Code Blue team, which consisted among others of the resident medical officer, nurses from the Intensive Care Unit and DW6.

(iii) Subsequently, the deceased was treated by DW1, DW3, a haematologist, two general surgeons, a cardiologist and two anaesthetists. The availability of consultants from several fields in the early hours of the morning on a Sunday speaks volumes of the care offered by the second defendant.

[80] Thirdly, there is no causal link between the absence of a written protocol and the patient's death which was caused by AFE is borne out in the evidence of DW2 under cross-examination by the plaintiffs' counsel:

Q : I put it to you that if there had been a protocol, it's probable that a safe obstetrics practice would have been complied with and this patient would not have suffered, this patient would not have died my lady, I think I'll just cut it short.

A : My Lady, every maternal death is a tragedy.

Unfortunately, there are some which we are unable to avoid and one classic example is AFE which leads to quick succession of events of cardiac dysfunction, DIVC and bleeding which aggravate each other and causes the difficulty when tackling the situation.
See DW2 NOE 14/4/2011 p. 228 & 229. (emphasis added)

Time Taken To Respond To Obtain And Transfuse Blood

[81] The plaintiffs argued there was a delay in transfusing the patient with blood. I do not find there is merit in this contention for the following reasons:

(i) Blood was grouped and cross-matched within an hour and this is not unreasonable given the patient's veins had collapsed and there was difficulty drawing blood as per the testimony of Dr Chua (DW4), (NOE 16 June 2011 p. 48);

(ii) Even Dr Lim (PW2) agreed that the decision to order for cross-matched blood at 4am hours was correct and that it would take an hour to cross-match the blood (NOE 6 December 2010 pp. 39-40).

[82] The plaintiffs contended that the patient ought to have been given O-negative blood immediately. This contention is untenable as it has ignored the following evidence:

(i) DW3 and DW4 both testified that O-negative blood was not readily available in private medical centres in the year 2000, or for that matter even today. DW4 testified that blood is only available from the National Blood Transfusion Centre, and that private hospitals are not allowed to have their own blood donation drive (DW4 NOE 23.6.2011 p. 98).

A similar sentiment is shared by DW5 who stated:

> A : In my experience as an inventionist I have found that O negative blood is not usually available at short notice. Even when it is available, it is often in insufficient quantities for any significant blood loss in an adult.

(ii) DW4 confirmed that less than 2% of the population has Rhesus D-blood type and part of that "less than 2%" is O-negative. Even PW2 agreed to this statement. Therefore it is impossible for a private hospital to have a sufficient amount of O-negative blood available at all material times.

(iii) DW5 testified (i) that giving blood is rarely the first line of response, (ii) when the patient's blood pressure collapses, the first line of treatment is to rapidly infuse crystalloids and/or colloids as was done in this instant case and (iii) that even if the blood was available at 4.10am it would not have avoided the subsequent cardiac arrest in the patient which was caused by AFE (NOE 23.6.2011 p. 18; pp. 19 and 47).

Breach Of Duty On The Accepted Standard Of Care *Vis-a-vis* The Second Defendant?

[83] Without prejudice to my findings in respect of the allegations of negligence raised by the plaintiffs against the second defendant, I shall now consider the issue of whether the plaintiffs have discharged their onus of establishing that the second defendant has breached the standard of care required of private hospitals in Malaysia "with a high degree of probability". (*Whitehouse v. Jordan & Anor* [1980] 1 All ER 650 cited in *Arulappan Kannan v. Dr Suresh Chopra & Ors* [2011] 3 CLJ 662 (HC) at p. 676).

[84] In this regard before considering whether the second defendant has breached the standard of care, it is incumbent for the plaintiffs to first prove what exactly the standard of care was in private hospitals in Malaysia in the year 2000. From PW2 and PW3, the following is gathered of their location of medical practice:

(a) (i) PW2 practised for only four years in Malaysia (1981-1985) (15 years prior to the patient's death) in a government hospital (University Hospital) and thereafter continued his practice abroad from 1985 till to date (exh. P1-PW1's CV)

(ii) PW2 confirmed in cross-examination, since 1985, apart from UK he practised in New Zealand but not in Malaysia; neither has he practised in any private hospital in Malaysia.

(iii) PW2 admitted that his testimony is based on his practice in hospitals in UK.

(iv) PW2 confirmed that he has no firsthand knowledge of the condition in cardiac medical centres in Malaysia relating to the storage of blood, as to what blood is kept on site, off site etc.

(b) PW3 stated he has never worked in Malaysia and his evidence is based on practices adopted in hospitals in England.

[85] Based on the aforesaid evidence in my assessment PW2 and PW3 are not competent to testify on what constitutes the standard of care required of private hospitals in Malaysia as an expert witness:

(i) should provide independent assistance to the court by way of objective unbiased opinion in relation to the matters in dispute,

(ii) should make it clear when a particular question or issue falls outside his expertise (*National Justice Compania Naviera SA v. Prudential Assurance Co Ltd* [1993] 2 Lloyd's Rep 68 at p. 81).

[86] On behalf of the defendants, the following evidence was gathered from DW2, DW3 and DW5 (expert witnesses) and DW1 and DW4 (factual witnesses):

(i) DW2 (Professor Sir S Arulkumaran) agreed that it would not be appropriate to automatically adopt the Green Top Guidelines (of which he is the author) to private hospitals in Malaysia, thus there is a qualifier on p. 1 para. 1 last sentence which reads "recommendations may be less appropriate for other settings where facilities, resources and routine practice differs".

DW2 did not find the management of the patient to be wanting (NOP 14 April 2011 pp. 160-161, 179-180).

(ii) DW4 (Dr Chua) testified that the absence of a written protocol did not in any way jeopardise the health and safety of the patient as "this is the accepted way we practice". This is the way we have been taught to respond to emergencies. Call primary doctor, call for help and institute resuscitative measures while waiting for the rest to respond".

(iii) DW5 (Dato' Dr Mohamed Hassan Ariff) testified:

> As I have said, this is the author's opinion, it varies different parts of the world and different part of blood banking services. You cannot take the standard of one university hospital in America or England and try and apply it in Malaysia. If it is the standard then the Ministry of Health would give guidelines that blood must be available within 30 minutes. I must stress that paragraph 2 also

states that clinician must be aware of the capabilities of the blood bank regarding timing and type. So it is not being absolute. So the paragraph there is with conditions. Paragraph also states good communication with transfusion service is essential. And in this case, the haematologist was present at 0550. Anywhere in the world you won't get a haematologist at 0550. See DW5 NOE 23/6/2011 p 40 & 41).

[87] Based on evidence of the defendants' witnesses, I agreed with the submission of the second defendant that "one cannot lay down standard of care for private hospitals in Malaysia purely by reference to standard of care for private hospitals in England, Canada or Australia, particularly where the Malaysian Ministry of Health itself has not seen it fit to do so".

[88] The plaintiffs relied on the case of *Bull and Another v. Devon Area Health Authority* [1993] 22 BMLR 79 to argue that a failure of a hospital to have a safe obstetric system in place would be tantamount to negligence as is the case against the second defendant. The case can be distinguished as it is based on the practices in the UK which cannot be simply transposed to this country. In any event, DW1 has testified that it was not the standard practice in private hospitals in Malaysia to have an obstetrics medical officer in the year 2000 and DW2 (NOE 14 April 2011 p. 244) and DW3 (NOE 24 June 2011 p. 99) confirmed this to be so.

[89] Therefore I conclude there is no reliable evidence as to what is the applicable standard of care for private hospitals in Malaysia in the year 2000 which the second defendant has breached. On this ground alone the court is entitled to dismiss the claims of the plaintiffs.

Vicarious Liability

[90] The plaintiffs argued that (i) PW1 and the patient did not have knowledge of the private contractual arrangements between the first and second defendants and (ii) in any event the second defendant owed the patient a non-delegable duty meaning that the second defendant would be liable for the acts and omissions of the first defendant as the second defendant is under a non-delegable duty to treat patients which cannot be discharged by delegating it to a consultant (first defendant) under a contract of services. (*Cassidy v. Ministry of Health* [1951] 1 All ER 574, *Liau Mui Mui v. Dr R Venkat Krishnan* [1999] 1 CLJ 207, *Dr Wong Wai Ping & Anor v. Woon Lin Sing & Ors* [1999] 6 CLJ 23 were cited by the plaintiffs).

[91] In the case of *Farraj and Another v. King's Healthcare NHS Trust and Another* [2009] All ER (D) 158 (cited by the second defendant), the English Court of Appeal after referring to the case of *Gold v. Essex*

County Council [1942] 2 KB 293, *Cassidy*'s case (*supra*) and *Roe v. Ministry of Health* [1954] 2 All ER 131; [1954] 2 QB 66 stated that that:

> there were two schools of thought as to whether a hospital owes a personal non-delegable duty to provide its patients with skilful treatment and as to whether it is liable for the negligent acts and omissions of those who provide treatment, whether they are employees of the hospital or engaged by it as independent contractors. The **majority view** was that the hospital was liable because it is vicariously liable for the negligence of its employees. *But Lord Greene MR in Gold and Denning LJ in Cassidy and again in Roe founded liability on the wider basis that the hospital is liable for the negligence of those who administer treatment in its hospital, regardless of their employment status* …"[I]t now seems clear, following suggestions by Denning L.J.[in the case of *Cassidy* (*supra*)] and a subsequent decision by the High Court of Australia, that health authorities are under a personal, non-delegable duty to see that care is taken in providing treatment, analogous to the non-delegable duty owed by an employer to his employees. … and it has since been decided, in accordance with this principle, that a health authority which contracts out services to an independent contractor is liable for any fault exhibited by the latter. *However, the limits of this principle should be noted. It does not apply where an authority enters into a private arrangement to supply services by contract: nor, it is submitted, does it apply to negligence on the part of a consultant or surgeon specifically chosen by the patient.* (emphasis added)

[92] When cross-examined by the second defendant's counsel, the first defendant (DW1) stated he was an independent contractor and was not a salaried employee.

[93] Unlike what the plaintiffs seem to contend that they have no knowledge of the private contractual arrangements between the first and second defendants, there is the evidence to the contrary in that the patient upon admission to the second defendant hospital on 4 November 2000 had signed acknowledging that she has read and received a copy of (the conditions of service attached to the registration form (bundle D pp. 1-3) and "irrevocably agree to be bound and comply with the conditions of service". Likewise her husband the first plaintiff, has knowledge of the same conditions having signed as guarantor (bundle D p. 3) where he, *inter alia*, "agree to be bound by all the above conditions". And one of the "conditions of service" (bundle D p. 2) at para. 4 reads:

> 4. Hospital Consultants
>
> All consultants in this Hospital are independent practitioners and it is the responsibility of the consultant to obtain the patient's consent when required for medical or surgical treatment and procedures. The instruction of the consultants will be carried out by the Hospital and its nursing staff.

[94] Further the evidence revealed that the patient has specifically chosen the first defendant as her obstetrician and she has engaged the first defendant herself where "the patient was introduced to (the first defendant) by her older sister". (NOE DW1 12 April 2011 p. 8).

[95] Thus based on the available evidence I am satisfied that the exception alluded to in *Farraj*'s case (*supra*) applies and the second defendant is correct in submitting that the doctrine of non-delegable duty is inapplicable.

Other Matters

Witnesses Of Fact Not Called As Witnesses?

[96] I am of the view that the plaintiffs' invocation of s. 114(g) of the Evidence Act 1950 against both the first and second defendants with respect to the non-calling of Dr Anne Tay (pathologist), Dr Raja (resident medical officer), Dr Rudy Yeoh (haematologist), operating theatre nurses, midwife Asmah and the blood bank representatives as witnesses is unwarranted. The reasons are as follows:

[97] With regard to Dr Anne Tay, since it is the plaintiffs who are suggesting that the histopathology report is incomplete or inaccurate, it is for the plaintiffs to call the said doctor if they wish to substantiate their allegation that there could have been a uterine rupture which was not documented.

[98] Dr Raja's involvement has been documented in the Nursing Care Plan and report on the patient by the nurses on duty and his presence is unnecessary.

[99] Midwife Asmah's role is comparatively minor as opposed to Midwife Asmah who was a material witness and was with the patient from 9am, before the delivery until the patient was sent to the ICU at 6am, 5 November 2000. Further during this period of time she was the midwife who made the entries in the Nursing Care Plan (bundle D pp. 49-51 and transcript in bundle D pp. 53-55).

[100] The evidence of the operating theatre nurses is irrelevant.

[101] In my view the evidence of Dr Rudy Yeoh's and the blood bank representatives are not material as there is ample evidence from DW1, DW3 and DW4 in respect of the availability of blood at the material time in the hospital. In any event since the issue of availability of blood is an issue raised by the plaintiffs the onus is upon them to call these persons as witnesses if they deemed it necessary.

[102] Finally this is not a case where the defendants are withholding or suppressing evidence and therefore s. 114(g) is inapplicable (*Munusamy v. Public Prosecutor* [1987] 1 MLJ 492 (SC) at p. 494 paras. B-C left column, *Sistem Penyuraian Trafik KL Barat Sdn Bhd v. Kenny Heights Development Sdn Bhd & Anor* [2009] 4 CLJ 57 (CA) at p. 82 para. 60, *Pekan Nenas Industries Sdn Bhd v. Chang Ching Chuen & Ors* [1998] 1 CLJ 793; [1998] 1 MLJ 465 (FC) at pp. 472 and 519 at paras. 6 and H-I respectively).

Comments On Defendants' Experts And Evidential Value

[103] I find the defendants' expert witnesses are experts in their own area of expertise who acted professionally despite the vigorous cross-examination. After assessing their evidence *vis-a-vis* whatever relevant contemporaneous documents or medical literature referred thereto by them I have no reason to doubt their credibility.

Conclusion

[104] Undoubtedly the death of the patient was a traumatic and tragic event. However based on the oral and documentary evidence, the medical literature and the law, this court has no other option but to dismiss the plaintiffs' claims with costs to be taxed unless otherwise agreed as I find on a balance of probabilities:

(a) on the pleadings alone, there is a material departure from their pleaded case;

(b) the plaintiffs have failed to prove their pleaded case in that the patient's death was caused by PPH in the course of induction or excessive bleeding due to a uterine tear;

(c) the plaintiffs have failed to establish that the second defendant has breached the applicable standard of care for private hospitals in Malaysia;

(d) even if I were to err on item (c) in relation to the second defendant, the defendants have not breached their duty of care to the patient and caused or materially contributed to her death. The plaintiffs have not proven there was massive ongoing blood loss that was not noticed by the first or second defendants or neither was there concealed bleeding that was not recognised by the first or second defendants. In short the plaintiffs have not proven that the cause of the patient's death was PPH that was not attended to by the defendants; rather it is this court's finding that the patient died due

to AFE which took place shortly after 4am on 5 November 2000 and as medical literature discloses patients who suffered a cardiac arrest the percentage of survival is 8%. Thus in this instant case the patient succumbed to AFE despite the efforts made by the first defendant and team of medical specialists and medical support staff in the wee hours of the morning of 5 November 2000.

(e) on the question of vicarious liability in relation to the second defendant, even if the first defendant is negligent (which I hold otherwise), the second defendant is not vicariously liable for the first defendant's acts and omissions.